

DPH ICD-10 Project Update

August 29, 2014

Solicitation for Local Health Departments to Participate in NCTracks Provider/Trading Partner End-to-End (E2E) Testing scheduled to begin April 2015: End-to-end testing is where payers (NCTracks) will learn how ICD-10 claims are being adjudicated and providers will learn the effect on reimbursement. That's because the end result should be the production and transmission to the provider of an electronic remittance advice. End-to-end testing is critical since the adjudication logic for member benefits, medical policies, referrals, preauthorizations and other functions may react differently in ICD-10 based on how a payer has redefined the functions in ICD-10 or cross-walked these functions. On pages 5-7 of this communication is additional information regarding ICD-10 testing. This information will help agencies better understand the purpose of the testing and expectations of testing agencies.

DPH has requested 10 provider/trading partner slots so that testing with NCTracks can be done with HIS for both LHDs and CDSAs and then each non-HIS vendor system can test (e.g., Insight, Patagonia, Allscripts, etc). The local health departments are very fortunate to have the opportunity to participate in the E2E testing so they can understand the possible impacts that ICD-10 will have on the way they do ICD-10 coding, reimbursement impacts, areas of concern that need to be shared with Medicaid, etc. Test sites will need to select cases for testing and then code those cases using ICD-10. Much more information regarding the test claims will be provided by NCTracks once test sites are identified. The local agency ICD-10 Implementation Teams are encouraged to weigh the benefits of being a test site.

The NCALHD Informatics Committee has approved the process for selecting health departments that will be included in the E2E testing.

- On Page 4 of this communication is a one page application for health departments to complete no later than September 30, 2014 if they are interested in participating in the testing with NCTracks.
- The DPH ICD-10 Implementation Project Manager will review all applications and indicate if the applicant is viable for testing. If there is only one applicant for a particular practice management system (e.g., Patagonia, Allscripts, HIS) that agency will be selected.
- When there are multiple viable applicants for testing a practice management system, the DPH ICD-10 Implementation Project Manager and HIS Business Support team members will make the final selection.

For questions regarding the testing or application process, e-mail Sarah.Brooks@dhhs.nc.gov

ICD-9-CM and ICD-10-CM Code Book Purchases: There were no code updates for either ICD-9-CM or ICD-10-CM effective for October 1, 2014 so it is not necessary to purchase new code books this year.

September 2014 Coding Training for Local Health Departments and Rural Health Agencies: ICD-10-CM coding training is being offered during September 2014 for local health department and rural health agency staff who are working on ICD-10 implementation within their agency and for DPH staff that are impacted by ICD-10 or who may provide assistance to local agencies (e.g., nurse consultants). The number of course offerings is very limited since the number of registrants needing training in 2014 should be low. Extensive ICD-10-CM coding training will be offered in 2015 prior to the 10/1/15 compliance date for DPH, child development service agencies (CDSAs), local health departments and

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rural health agencies. It is anticipated that course offerings will be conducted between May – September 2015. Training registration information is located at <http://ncpublichealth.info/lhd/icd10/training.htm> .

By September 2nd, the ICD-10-CM Basic Training course slides and workbook should be available at <http://publichealth.nc.gov/lhd/icd10/training.htm> . Participants are requested to print out, at a minimum, the quiz and coding exercises from the workbook. The specialized course materials will be posted on the website 2 days prior to the training. Access to an ICD-10-CM code book during the training is critical. The year the book was published should not matter (e.g., 2012, 2013, 2014, 2015).

There are different URLs for each of the different courses being offered as specified below. Participants who have registered should receive an e-mail that includes the link for each course 5 days prior to each course offering.

Basic Coding Training: <https://ltat-ncdph.adobeconnect.com/basic-icd10/>

Specialized Coding Training:

- Behavioral Health: https://ltat-ncdph.adobeconnect.com/icd-10-behavioral_health/
- Child Health: https://ltat-ncdph.adobeconnect.com/icd-10_child_health/
- Family Planning: https://ltat-ncdph.adobeconnect.com/icd-10_family_planning/
- Maternal Health: https://ltat-ncdph.adobeconnect.com/icd-10_maternal_health/
- Primary Care, Women's Health, Chronic Disease, BCCCP: https://ltat-ncdph.adobeconnect.com/icd-10_primary_care/
- STD, HIV, Communicable Disease: https://ltat-ncdph.adobeconnect.com/icd-10_communicable_dz/

Coding Exercises: Here is the answer for the scenario from the last communication.

Scenario: A man from a small village in Guinea, West Africa, presented to his village health clinic with a severe headache, vomiting, diarrhea and severe pains in his back. He was initially thought to have malaria, but upon transfer to a special unit at a hospital in Conakry he was diagnosed with Ebola. The patient went on to develop disseminated intravascular coagulopathy, SIRS and shock. The patient was treated with intravenous fluid and electrolytes, vitamin K, oxygen and blood pressure support. He eventually succumbed.

Answer: A98.4 Ebola virus disease; R65.21 Severe sepsis with septic shock; D65 Disseminated intravascular coagulopathy

ICD-10 provides a specific code, A98.4, for *Ebola virus disease*. It is located in the Alphabetic Index under the main term Ebola virus disease, or Disease, Ebola (virus). In ICD-9, Ebola is indexed under Infection, Virus, Ebola resulting in code 065.8, *Other specified arthropod-borne hemorrhagic fever*. Lack of specificity in the ICD-9 code description makes it difficult to clearly identify Ebola patients. This in turn makes it difficult to monitor and track the disease from a public health perspective and impacts the ability to perform research, measure outcomes, evaluate efficacy of treatment, etc. The difference between the two codes illustrates that ICD-10 is more specific and more effective than ICD-9 in capturing public health diseases.

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Code R65.21, *Severe sepsis with septic shock*, should also be assigned to classify the SIRS and shock as documented. The instructional notes at subcategory R65.2- remind us to code the underlying infection first and to assign additional code(s) for the acute organ dysfunction, Consequently, D65 is assigned for the *disseminated intravascular coagulopathy*.

It would not be appropriate to assign a code from subcategory R65.1-, *Systemic inflammatory response syndrome (SIRS) of non-infectious origin*, because the SIRS is of an infectious origin. The infection is the Ebola virus disease.

New Scenario: A 65-year old female was seen as an outpatient by her internist for monitoring of her hypertension and type II diabetes mellitus. During the course of the visit, the patient told her physician that she had been feeling sad and depressed as of late. After discussion, the patient agreed to a trial of antidepressant medication therapy. Prescription renewals for enalapril and metformin along with a new prescription for the antidepressant were sent to the patient's pharmacy electronically. The diagnoses for the visit were hypertension, Type II diabetes mellitus and depression.

Assign ICD-10-CM diagnosis codes for this scenario. Answer will appear in the next communication.

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APPLICATION TO QUALIFY FOR END-TO-END TESTING WITH NCTRACKS

Health Department Name: _____

Primary Contact Name, E-mail address, Phone#: _____

Practice Management Software: ☐ HIS ☐ Insight ☐ M & M Visual Health Net
☐ CureMD ☐ Allscripts ☐ Patagonia
☐ Cerner ☐ GE, Centricity ☐ McKesson

Is your Practice Management software ICD-10 compliant?

If yes, has your staff done internal testing related to ICD-10? ☐ Yes ☐ No

If no, when will your vendor provide ICD-10 compliant software? _____

Do you have access to a test environment that can accept entry of the test claims?

- ☐ Yes, test environment is in-house
- ☐ Yes, through our vendor
- ☐ No

Does your agency have an active ICD-10 Implementation Team? ☐ Yes ☐ No

If yes, will the Implementation Team conduct the testing? ☐ Yes ☐ No

If no, who will conduct the testing? _____

Do you have at least 2 staff members who have attended ICD-10-CM coding training in the past or plan to attend the training that will be held in September 2014? ☐ Yes ☐ No

NCTracks testing is scheduled to occur April 2015 – June 2015. Will your staff be available during that time period to perform testing including preparing test cases (prior to April 2015), data entry of test cases and claims submission, review of test results, trouble-shooting with NCTracks, etc.? ☐ Yes ☐ No

For the month of July 2014: Number of Medicaid claims sent to NCTracks _____
Number of Medicare claims _____

Comments/Questions: _____

Submit completed application to: Sarah.Brooks@dhhs.nc.gov no later than **September 30, 2014**

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ICD-10 Testing

Among the multitude of tasks to prepare for the ICD-10 code sets, providers should conduct two core tests with insurers: Acknowledgement testing and End-to-End testing.

Acknowledgement Testing

Under acknowledgement testing, a provider submits a claim to a payer, which is checked for appropriate HIPAA 5010 transaction standard edits, ICD-9 and ICD-10 edits, and transaction dates, with the goal of verifying that the payer can accept the claim. But this test does not tell a provider how an ICD-10 claim will adjudicate, so providers won't know if the resulting reimbursement will be revenue neutral or different. Providers should do acknowledgement testing through their clearinghouse by submitting test claims to different payers to ensure payers will be able to receive the claims.

End-to-end Testing

End-to-end testing is where payers will learn how ICD-10 claims are being adjudicated and providers will learn the effect on reimbursement. That's because the end result should be the production and transmission to the provider of electronic remittance advice. End-to-end testing is critical since the adjudication logic for member benefits, medical policies, referrals, preauthorizations and other functions may react differently in ICD-10 based on how a payer has redefined the functions in ICD-10 or cross-walked these functions. End-to-end testing involves specific scenarios that include three parts

- Clinical information on the patient
- How information is converted into ICD-9 or ICD-10 codes
 - For example, there are NCTracks edits and audits that require certain diagnoses to be associated with certain CPT procedure codes so testing will help identify changes that may be needed such as specifying laterality or trimester in diagnostic codes
- The methodology adjudicated

It will be important to analyze your organizations data to determine where to focus efforts by defining those scenarios that are most likely to reflect those areas that matter the most. It is not realistic to identify every process and potential area of risk, but risks can be identified and minimized by picking testing scenarios that represent:

- High Volume
- High Cost/Revenue
- Anticipated opportunities for improvement of existing processes

Providers need to identify historical claims adjudicated in ICD-9 and create ICD-10 versions of the claims for adjudication. Providers and payers then need to compare the differences and see if they can agree on the differences so providers get a baseline on how claims will adjudicate under ICD-10. This testing will address such questions as: Are benefits coded appropriately? Was the claim paid appropriately by the payer? According to CMS, "the end-to-end testing process should be performed in an environment which mirrors actual production as closely as possible confirming the validation of performance metrics and analytics." Ensure that records used for testing are based on actual clinical scenarios.

Testing analysis should include:

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- Number of claims accepted vs. rejected
- Cases for which denials occurred and specific reasons for any denials, if available
- Cases for which additional documentation was requested - and why
- Revenue expectations vs. actual outcomes

A sampling of local health departments in NC will have an opportunity to be involved in end-to-end testing with NCTracks so any issues with the adjudication process can be identified and resolved prior to the 10/1/15 compliance date for ICD-10.

Preparing Test Cases

NOTE: NCTracks will need to provide guidance on certain aspects of the test cases such as testing with future dates, Medicaid IDs to be used, etc.

Find encounters which represent the test scenarios identified for your agency

- Locate at least 15 existing encounters/claims that match the test scenarios that have already been billed and paid

Prepare test cases

Prepare test cases using the encounters identified above. Utilize the ICD-9-CM codes/descriptions found in the encounters/claims and then code the information using ICD-10-CM. If you need assistance, contact the DPH ICD-10 Implementation Project Manager. Note – You should natively code in ICD-10-CM. Only use crosswalks and mappings as a point of reference.

Include different dates of service in your test cases

- For most of the cases, use ICD-10-CM codes and simulate a date of service on or after 10/1/2015.
- Incorporate at least one case using an ICD-9-CM code and simulate a date of service on or after 10/1/2015. This case should fail since ICD-10-CM codes are required with dates of service on or after 10/1/15.
- Include at least one case using an ICD-10-CM code and simulate a date of service before 10/1/2015. This case should fail since ICD-9-CM codes are required for dates of service before 10/1/15.

Prioritize the stakeholders with whom you need to perform external testing

- Plan to test with the clearinghouse or payers that have the greatest revenue impact on your agency.
- Contact your agency's clearinghouse to affirm that they are able to receive test claims and the payers they are testing with.
- NCTracks testing of Medicaid claims will be coordinated through the DPH ICD-10 Implementation Project Manager.

Submit test data to your clearinghouse, billing service and/or payer(s).

- Submit data to your vendors or payers using your test cases:
 - Send the data electronically if you have a system with the capability to do so.

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- If your system is unable to send electronic test transactions, submit test data using a mutually acceptable medium such as paper, a spreadsheet/Excel file, or direct entry through the vendor's or payer's website.
- Billing services and clearinghouses should take the data you submit and:
 - Generate electronic test transactions.
 - Send electronic test transactions to applicable payers on your behalf.
 - Forward test results to you once the transactions have been processed.

Review test results for the data you submitted to your clearinghouse, billing service, and/or payer(s).

- Verify test results for each type of test transaction which was processed:
 - Eligibility
 - Authorizations
 - Claims
 - Remittances
 - Quality and/or Public Health Reporting
- Evaluate test results for accuracy.
- Examine payments, rejections, and denials:
 - Categorize the primary reasons for denials and rejections.
 - Note claim payments that are different from what you expected.
- Review the test results with your vendor or payer to address your questions and gain a better understanding of the rules and edits that were applied. Address areas of concern.

Update your processes to address issues uncovered during testing.

Where appropriate, revise your documentation and billing processes to reduce rejections, denials, and payment errors moving forward.

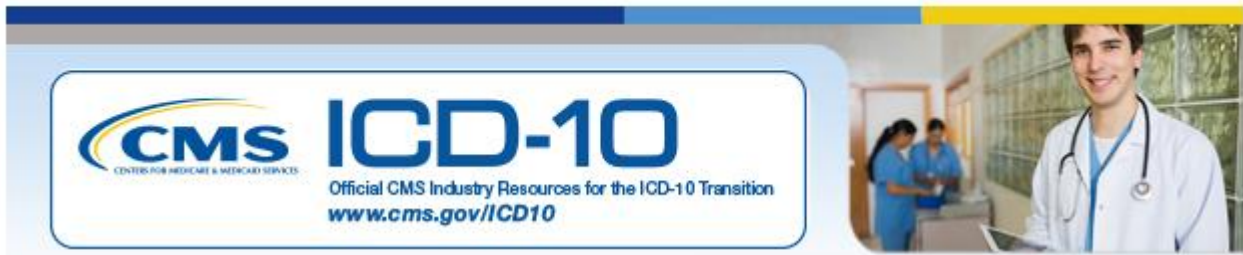
Submit test data to hospitals, HIEs/RHIOs, disease registries, public health organizations, and government agencies.

- Conduct testing if you exchange data containing diagnosis codes with these stakeholders.
- Submit data using your test cases:
 - Send the data electronically if you have a system with the capability to do so.
 - If your system is unable to send electronic test transactions, submit test data using a mutually acceptable medium such as paper, a spreadsheet/Excel file, or direct entry through the vendor's or payer's website.

Review test results for the data you submitted to your hospital, HIE, registry, public health, and government agencies.

- Verify the following entities can accept ICD-10 data submitted from you:
 - Hospitals
 - HIEs/RHIOs
 - Disease Registries
 - Public Health Organizations
 - Government Agencies (Federal, State, Local)
- Validate you can process ICD-10 diagnosis codes you receive in exchange.
- Address areas of concern with these entities.

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ICD-10. COMPLIANCE DATE OCTOBER 1, 2015

News Updates August 19, 2014

CMS Releases ICD-10 Clinical Documentation and Coding Webcast

The Centers for Medicare & Medicaid Services (CMS) has released a new webcast with information on clinical documentation and coding from the "Road to 10" tool, which was designed to help small physician practices transition to ICD-10. Accessible through the "Road to 10" link on [the CMS website](#), the webcast discusses how transitioning to ICD-10 will impact documentation and coding in small physician practices. This is the third webcast in the new "Road to 10" series. Three more webcasts will follow—all aimed at helping providers get ready for ICD-10 by the October 1, 2015, compliance date. Go to [the CMS ICD-10 website](#) to get started on the "Road to 10" today.

Keep Up to Date on ICD-10

Visit the CMS [ICD-10 website](#) for the latest news and resources to help you prepare. Sign up for [CMS ICD-10 Industry Email Updates](#) and [follow us](#) on Twitter.



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External Cause Codes – Why are they important??

Q: Although external cause codes are not mandatory, I know that many states and reporting agencies require organizations to report them. I also know that they're helpful in terms of injury research and evaluation of injury prevention strategies. From what I've read, ICD-10-CM includes many expansions for these codes. What are some of the most significant ones on which we should focus our attention?

A: ICD-10-CM includes many expansions for external causes. These codes - which indicate how an injury or health condition occurred, the intent, the place where the event occurred, the activity in which the patient was engaged at the time of the event and the patient's status - are included in Chapter 20 (category V01-Y99).

A quick review of Chapter 20 reveals many, many highly specific codes, some of which a coder may never code in his or her career. Others, however, may be more relevant. It's helpful for someone within the organization to review this chapter and highlight codes that may be important for your specific population. For example, these three external cause codes will likely apply to many institutions:

1. Y92.01- (single-family non-institutional [private] house as the place of occurrence of the external cause). Many events happen within the home, and it's now important to further specify whether the event occurred in the kitchen, dining room, bathroom, bedroom, private driveway, private garage, swimming pool or garden/yard. If the event did not happen in the patient's home, coders have a whole host of other places of occurrence from which they can choose, each of which requires a similar level of specificity.
2. Y93.C2- (activity involving hand-held interactive electronic device). This code denotes accidents that occur when drivers are distracted by a cell phone or other electronic device. Unfortunately, these accidents all occur too frequently, and organizations should capture as many details as possible to assist with research that can target prevention and education.
3. Y07.- (perpetrator of assault, maltreatment and neglect). Codes in this category denote the specific perpetrator (e.g., husband, female partner, foster mother, male cousin, or teacher). Coders should only report these codes for cases of confirmed abuse.

Consider these strategies for success:

- Review ICD-10-CM category V01-Y99. What codes may be most appropriate for your organization based on patient population, top DRGs, and provider feedback?
- Identify what additional documentation may be required for these codes.
- Incorporate documentation requirements into templates and/or queries.
- Educate physicians and CDI specialists about new requirements and focus on how this information can assist with research and better patient care.